

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35445

STATE FILE NUMBER

FILED OCT 21 1957

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 982

5. 300
1-57

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield		c. CITY OR TOWN Springfield	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mercy Hospital		d. STREET ADDRESS 931 W. Poplar	
3. NAME OF DECEASED (Type or print) First Middle Last LON MANFORD HENDERSON		4. DATE OF DEATH Month Day Year October 11 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 15, 1875
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telegrapher		9b. KIND OF BUSINESS OR INDUSTRY Railway	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telegrapher		11. BIRTHPLACE (City and state or country) Lexington, Missouri	
13a. FATHER'S NAME Claude Henderson		13b. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Carroll Conley, Springfield, Mo.		14. NAME OF HUSBAND OR WIFE ---	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Hypertension DUE TO (c) Senility - Possible ca of stomach			INTERVAL BETWEEN ONSET AND DEATH 443X H
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 10-3-57 to 10-11-57 and last saw ^{him} alive on 10-11-57 Death occurred at 12:50 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Paul O. Washaw, M.D.		22b. ADDRESS Springfield, Mo.	
22c. DATE SIGNED 10-12-57.		22d. NAME OF CEMETERY OR CREMATORY Newcomer's	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Oct 15, 1957.	
23c. NAME OF CEMETERY OR CREMATORY Newcomer's		23d. LOCATION (City, town, or county) (State) Kansas City Missouri	
24. FUNERAL DIRECTOR Jewell E. Windle, Springfield, Mo.		25. DATE RECD. BY LOCAL REG. 10-14-57	
26. REGISTRAR'S SIGNATURE Edith Williams			

All diseases in Part I must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

OCT 21 1957

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed Bernard F. Wright

Licensed Embalmer No. 4293
P. O. Address Springfield

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.